MONTHLY REPORT EA-214-02/03
TANF AND FOOD STAMP
STATE OF SOUTH DAKOTA
DEPT. OF SOCIAL SERVICES

CASEWORKER
ADDRESS
ADDRESS
PHONE NUMBER

CASE NUMBER
TANF ____ FS ____ MED ____

MONTHLY REPORT FOR PERIOD THRU
CASE NAME AND MAILING ADDRESS

IMPORTANT: LIST AND PROVIDE PROOF OF ALL CHANGES EVEN THOUGH YOU MAY HAVE ALREADY REPORTED THE CHANGES TO THE TANF OR FOOD STAMP OFFICE.

THIS REPORT MUST BE COMPLETED, SIGNED AND RETURNED TO YOUR LOCAL OFFICE BETWEEN THE 15TH AND THE 20TH OF THE MONTH. DO NOT COMPLETE OR SUBMIT BEFORE THE 15TH. ANSWER ALL QUESTIONS. YOU ARE REQUIRED TO REPORT ON THIS FORM ANY CHANGE IN CIRCUMSTANCES WHICH YOU EXPECT WILL OCCUR THIS MONTH AND NEXT MONTH.

IF YOUR FORM IS INCOMPLETE OR NOT TURNED IN ON TIME, YOUR CASE WILL BE CLOSED.

AGENCY USE ONLY:

DATE RECEIVED

HOUSEHOLD MEMBERS

1. CURRENT MEMBERS

Please tear along this line to open

2. ____ YES ____ NO **PERSONS LEAVING THE HOUSEHOLD:** Has anyone moved out or do you expect anyone to leave your home? If YES, complete the boxes below.

NAME	DATE LEFT/LEAVING	REASON FOR LEAVING

3. ____ YES ____ NO **NEW HOUSEHOLD MEMBERS:** Has anyone moved into your home or do you expect anyone to move into your home? If YES, complete the boxes below. Completion of SSN/Citizenship is optional for individuals not requesting assistance. Completion of race is voluntary and will not affect eligibility or benefits.

NAME	ARRIVAL DATE	RELATIONSHIP TO YOU	MARITAL STATUS	DATE OF BIRTH	SOCIAL SECURITY	U.S. CITIZEN	WILL NEW MEMBER EAT WITH YOU	RACE	SEX	STUDENT	LAST GRADE
						☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
						☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	

List income for new household members in the **INCOME** section. List resources for new household members in the **RESOURCE** section. If any new household member wants TANF or Food Stamps, contact your caseworker.

4. ____ YES ____ NO Are any new household members currently receiving food stamps or commodities? If YES, from where _____

5. ____ YES ____ NO Were there or does your household expect changes in school attendance? (such as not returning after summer break, not attending 2nd semester, reduced hours, start or quit school) If YES, list anyone in your home (preschool, head start, kindergarten, high school. college or boarding school) who started or quit school or reduced hours.

NAME	WHAT WILL OR DID HAPPEN	DATE OF CHANGE	NAME OF SCHOOL, OR TRAINING PROGRAM	BOARDING SCHOOL	HOURS PER WEEK	CURRENT GRADE
	☐ START ☐ REDUCED HOURS ☐ CHANGED ☐ SUMMER ☐ QUIT ☐ GRADUATED SCHOOLS BREAK			☐ YES ☐ NO		
	☐ START ☐ REDUCED HOURS ☐ CHANGED ☐ SUMMER ☐ QUIT ☐ GRADUATED SCHOOLS BREAK			☐ YES ☐ NO		

EXPENSES

6. ____ YES ____ NO Have you moved or do you plan to move? If YES. complete the boxes below and attach proof of expense, also list the utilities that you are responsible for paying. If mailing address is different than resident address, list both.

NEW ADDRESS	DATE MOVED	NEW AMOUNT OF RENT OR MORTGAGE	UTILITIES YOUR ARE RESPONSIBLE FOR PAYING
		$	

Is your only heat source wood	☐ YES ☐ NO	Do you pay for air conditioning?	☐ YES ☐ NO	Do you receive rental assistance?	☐ YES ☐ NO	Do you receive fuel assistance? (LIEAP)	☐ YES ☐ NO

6A. ____ YES ____ NO Do you live on an Indian reservation?

7. ____ YES ____ NO Have your housing costs changed because someone moved in or out of your household? If YES, list the amount, explain the change, and attach proof.

DESCRIPTION OF CHANGE	AMOUNT YOU PAY	DATE OF CHANGE
	$	

If you are receiving Food Stamps and do not have a heating or cooling expense, and would like a deduction for the following utilities, list the utility expense and attach proof of the expense.

COOKING $	LIGHTS $	WATER $
GARBAGE $	SEWER $	PHONE $ (You need only provide proof if you are just beginning phone service this reporting month)

7A. ____ YES ____ NO ONLY ANSWER IF RECEIVING TANF. Has someone started or stopped paying your shelter expenses? If yes, explain

_____

8. ____ YES ____ NO Are you responsible for any child or adult care expenses? If YES, complete the boxes below and send proof of expense.

PERSON PAYING EXPENSE	PERSON IN CARE	DATE PAID	AMOUNT BILLED	TO WHOM PAID	REASON FOR CARE
			$		
			$		
			$		
			$		

9. ____ YES ____ NO Do you make court ordered child support payments to someone who is not a member of your household? If YES, complete the boxes below and attach proof.

AMOUNT PAID	DATE PAID	TO WHOM PAID
$		
$		
$		
$		

INCOME

10. ____ YES ____ NO Did anyone in your household receive money from work or training (such as a job, self-employment, tips, baby-sitting, or WIA)? For all household members, list all money received from the 15th of last month through the 14th of this month from work or training. You must send proof of the gross amount before deductions for all money received. If you are self-employed, you must submit itemization of your gross income and expenses. If YES, complete the boxes below.

PERSON WITH MONEY	PLACE OF EMPLOYMENT	DATE CHECK RECEIVED OR PAY DATE	GROSS AMOUNT BEFORE DEDUCTION	HOURS WORKED	AMOUNT OF TIPS	INCOME STOPPED	DATE OF FINAL CHECK IF JOB ENDED
			$		$	☐ YES ☐ NO	
			$		$	☐ YES ☐ NO	
			$		$	☐ YES ☐ NO	
			$		$	☐ YES ☐ NO	
			$		$	☐ YES ☐ NO	
			$		$	☐ YES ☐ NO	

10A ____ YES ____ NO Is your employment expected to last more than 120 days?

11. ____ YES ____ NO Before the end of next month, do you expect a change in money or hours from work or training (such as changing part-time to full-time, change in wages, etc.)? If YES, complete the boxes below.

PERSON TO WHOM CHANGE APPLIES	EXPLAIN THE CHANGE	NEW AMOUNT	EFFECTIVE DATE OF THE CHANGE
		$	
		$	

12. ____ YES ____ NO Did you or anyone in your household start or expect to start a new job? If Yes, complete the boxes below.

NAME	PLACE OF EMPLOYMENT	START DATE	WAGES PER HOUR	HOURS PER WEEK	DATE FIRST PAY RECEIVED	HOW OFTEN PAID
			$		$	☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Twice Monthly
			$		$	☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Twice Monthly

13. ____ YES ____ NO Did anyone in your household receive money from Social Security, SSI, VA, unemployment benefits, child support, alimony, rental income, BIA general assistance, TWEP, gifts of money or cash, workers or disability compensation, pensions, lottery or bingo prizes, or any other source? If YES, complete the boxes below and attach proof if this is a new source of money or the amount changed.

PERSON WITH MONEY	TYPE OF MONEY	DATE RECEIVED	AMOUNT
			$
			$
			$
			$

14. ____ YES ____ NO Before the end of the next month will Social Security, SSI, VA, unemployment benefits, child support/alimony, rental income, BIA general assistance, TWEP, gifts of money or cash, workers or disability compensation, pensions, or any other source start, stop, or change? If YES, complete the boxes below.

PERSON TO WHOM CHANGE APPLIES	EXPLAIN THE CHANGE	NEW AMOUNT	EFFECTIVE DATE OF THE CHANGE
		$	
		$	

RESOURCES

If anyone in your home buys, sells, trades, gives away or receives real estate or personal property, report it. Be sure to list resources of new household members. If you are listing property for the first time, please provide proof. All proof will be returned.

15. ____ YES ____ NO Were there or does your household expect changes in resources? If YES, check and complete the boxes below.

- ☐ CAR, TRUCK, CAMPER, BOAT, SNOWMOBILE, MOTORCYCLE (if checked, complete vehicle box.)
- ☐ CASH, CHECKING ACCOUNT, SAVINGS ACCOUNT, OR CERTIFICATE OF DEPOSIT (CD's)
- ☐ STOCKS, BONDS, SECURITIES, TRUST FUND, DEED, OR IRA's
- ☐ RECREATION PROPERTY, COTTAGES, BUILDINGS, OR LAND
- ☐ LIFE INSURANCE (CASH VALUE)
- ☐ LAND SALES
- ☐ BOUGHT, SOLD, TRADED OR GAVE AWAY REAL OR PERSONAL PROPERTY

				VEHICLE BOX		
PERSON WITH RESOURCE	TYPE OF RESOURCE	DATE OF CHANGE	VALUE	YEAR/MAKE/ MODEL	CURRENT VALUE	AMOUNT OWED
			$		$	$

Explain the change _____

MEDICAL

16. ____ YES ____ NO Has the private health insurance changed for any household member receiving medical assistance? If YES, complete the boxes below.

PERSON COVERED	NAME OF INSURANCE COMPANY	TYPE OF COVERAGE	POLICY NUMBER	GROUP NUMBER	START DATE	STOP DATE

OTHER INFORMATION

____ YES ____ NO Since your last monthly report form, are there any changes that have not already been reported in writing? If YES, explain. If you receive TANF, please include new information about absent parent(s).

The submission of SSN's for all household members requesting assistance is mandatory under the Food Stamp Act of 1977 as amended by Public Law 96-58 (7 U.S.C. 2025F). SSN's are used to check identity of household members, prevent duplicate participation, and to facilitate mass changes. They are also used in computer matching audits to make sure your household is eligible for food stamps. The household member who refuses or is unable to furnish a Social Security Number or citizenship status will be disqualified from the Food Stamp Program.

For the TANF Program, unless you have a good reason for having a late report, $10 will be deducted from the grant. This form will be returned to you if it is incomplete. However, if it is completed as instructed by your caseworker, your eligibility may be reinstated.

RIGHT TO A HEARING: As a recipient of public assistance you may request a hearing or conference if you believe any action of the department is incorrect, improper, or illegal. Hearing requests may be made either orally or in writing at any Social Services office, or directly to the Secretary of the Department of Social Services, Kneip Building, 700 Governors Drive, Pierre, South Dakota 57501. At both the conference or hearing, you may present your case yourself or with assistance from others, including legal counsel. The cost of legal counsel will not be the responsibility of the department.

I understand that my benefits (TANF, food stamps and/or medical assistance) may change or stop because of the information I have given on this report. I understand that such changes may be made without advance notice. I also understand that federal and state laws provide for fine and/or imprisonment of any person who fraudulently receives, or attempts to receive, public assistance, food stamps, or medical assistance to which that person is not entitled. Any person found to have committed an intentional Food Stamp Program, and/or TANF violation either through an administrative hearing or court of law, shall be disqualified from the Food Stamp Program and/or TANF for 12 months for the first offense, 24 months for the second offense and permanently for the third offense. THE INDIVIDUAL CAN ALSO BE FINED UP TO $250,000; IMPRISONED UP TO 20 YEARS, OR BOTH IF THEY ARE FOUND GUILTY OF UNAUTHORIZED USE OF FOOD STAMP BENEFITS.

If the Food Stamp office is not located where you live and you must call long distance to reach the office, you may call collect.

SIGNATURE OF RECIPIENT _____ DATE SIGNED _____ TELEPHONE NUMBER _____

RETURN THIS FORM TO YOUR LOCAL TANF ELIGIBILITY OR FOOD STAMP OFFICE WITH PROOF OF ALL CHANGES